

PLAINFIELD PUBLIC SCHOOLS – PERMISSION FOR ATHLETIC PARTICIPATION & PHYSICAL EXAM

NAME _____ SPORT _____

SCHOOL _____ GRADE _____

DATE OF BIRTH ____ / ____ / ____ PLACE OF BIRTH (City/State/Country) _____

CURRENT HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

PARENT/GUARDIAN NAME _____ Home Phone # _____

Work Phone # _____

Cell Phone # _____

Emergency Contact Person _____ Relationship _____ Phone# _____

I certify that the information provided herein is accurate as of the dated of these signatures

STUDENT: PLEASE READ AND SIGN BELOW: I UNDERSTAND THAT ATHLETIC PARTICIPATION IS A PRIVILEGE DEPENDENT ON MY GRADES AND CONDUCT. I AGREE TO FOLLOW THE STUDENT ATHLETIC HANDBOOK AND RETURN ALL EQUIPMENT LOANED TO ME IN THIS SPORT OR TO REIMBURSE THE SCHOOL FOR ITS LOSS.

STUDENT SIGNATURE _____

DATE _____

PARENT/GUARDIAN: PLEASE READ AND SIGN (1) AND (2) BELOW:

My son/daughter has my permission to participate in the above named sport conducted by the Athletic Department of the Plainfield Board of Education for the 2011-2012 school year. I am aware that participating in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team. REALIZING THAT SUCH ACTIVITY INVOLVES THE POTENTIAL FOR INJURY, WHICH IS INHERENT IN ALLSPORTS, I ACKNOWLEDGE THAT EVEN WITH THE BEST COACHING/TRAINING, USE OF THE MOST ADVANCED PROTECTIVE EQUIPMENT AND STRICT OBSERVANCE OF THE RULES, INJURIES ARE STILL A POSSIBILITY. ON RARE OCCASSIONS, THESE INJURIES CAN BE SO SEVERE AS TO RESULT IN TOTAL DISABILITY, PARALYSIS OR DEATH. I acknowledge that I have read and understand this warning. By this signature, I hereby consent to allow the physician(s) and other health care provider(s) selected by myself or the school to perform a pre-participation examination on my child and to provide treatment for any injury or condition resulting from participating in athletics/activities for his/her school during the school year covered by this form. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation in athletics and activities with coaches and other school personnel as deemed necessary. I understand that accident insurance purchased by the Board of Education provides coverage on an EXCESS basis only; I understand that this means only those expenses not covered by your personal or group insurance are eligible for coverage, and that in some cases not all expenses will be covered.

I certify that the information provided herein is accurate as of the dated of these signatures

(1) PERMISSION TO PARTICIPATE / PERMISSION TO PHOTOGRAPH PUPILS (POLICY 5145.5)

PARENT/GUARDIAN SIGNATURE _____

DATE _____

(2) PERMISSION FOR ATHLETIC PHYSICAL

I give permission for my son/daughter (NAME) _____ to receive an Athletic Medical Physical by the district's designated health care provider.

PARENT/ SIGNATURE _____

DATE _____

Date Received _____